End-of-Life Wounds and Palliative Wound Care

Saturday, May 16, 2020

3:10 – 4:10 PM

Post-Acute Care Symposium

May 15—16 | San Diego, CA

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Martha R. Kelso, RN, LNC, HBOT
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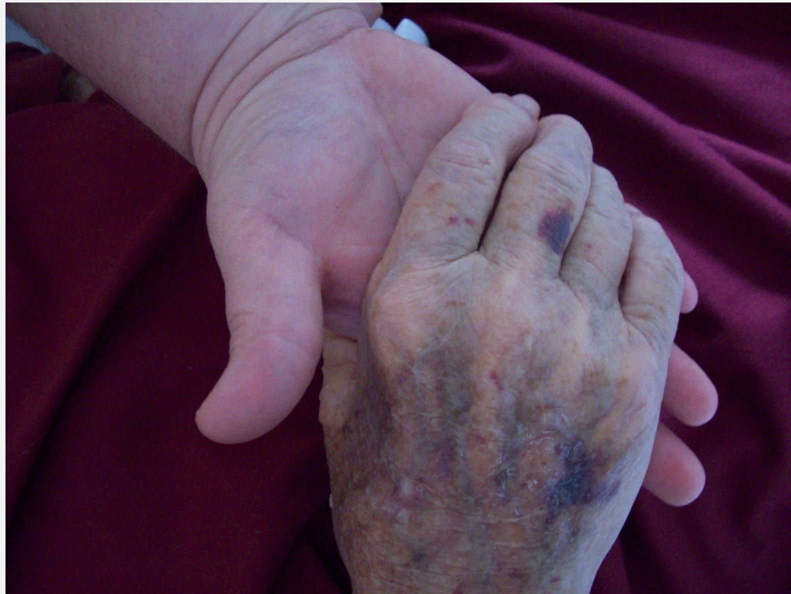

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Faculty Disclosures

Diane L. Krasner, PhD, RN, FAAN co-chaired the Skin Changes At Life’s End (SCALE) Panel

Martha R. Kelso, RN, LNC, HBOT, Nothing to disclose

Disclosures

The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational use(s) of drugs, products, and/or devices (any use not approved by the U.S. Food and Drug Administration).

- Applicable CME staff have no relationships to disclosure relating to the subject matter of this activity
- This activity has been independently reviewed for balance.

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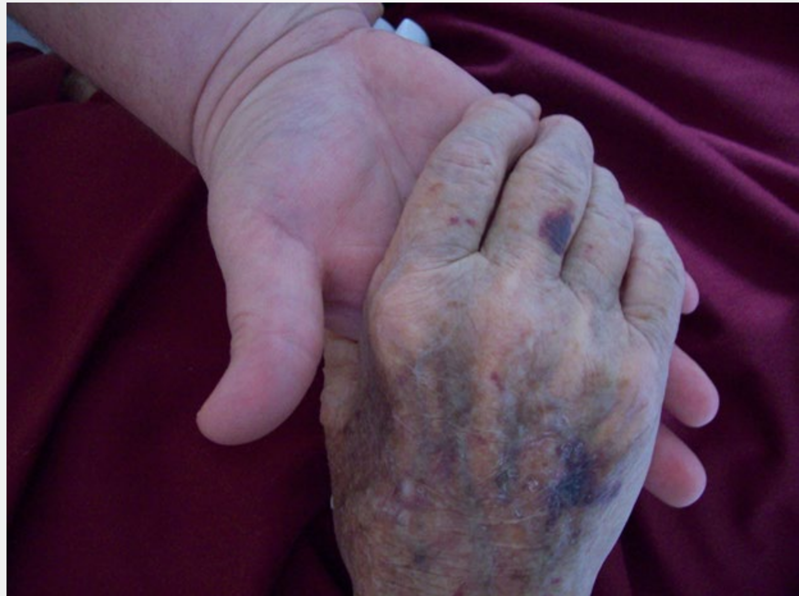

End-of-Life Wounds

Diane L. Krasner

Which of the following terms do you use in your facility for end-of-life pressure ulcers?

A. Kennedy Terminal Ulcer

B. Terminal Ulcer

C. We use another term

D. We don't use any term

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Which of the following terms do you use most often in your practice (select one only) for pressure ulcers / wounds in patients who are dying?

A. Kennedy Terminal Ulcer

B. Skin Failure

C. Skin Changes at Life's End

D. Other/None of the above

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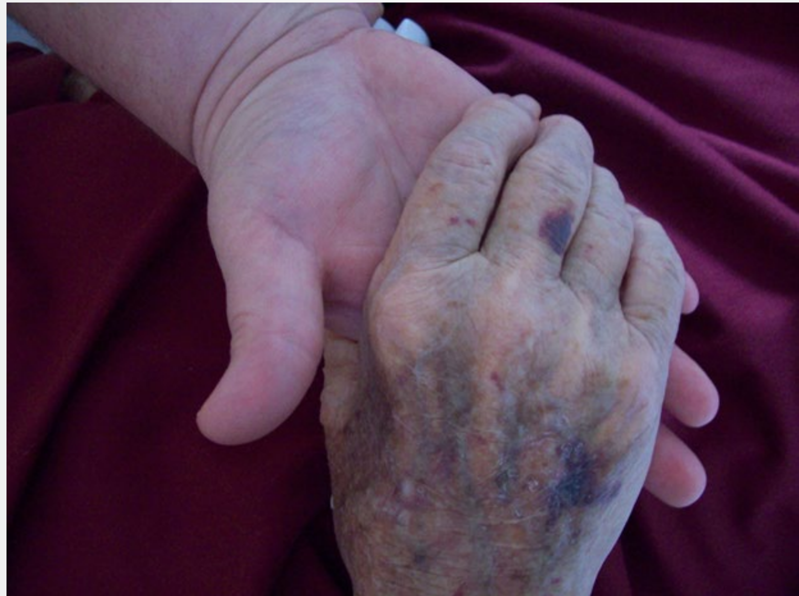

Background on End-of-Life Wounds

Historical Links between Pressure Ulcers & Death

Jean-Martin Charcot

Described 3 types of Pressure Ulcers including:

The Decubitus Ominosis

Lecture on Diseases of the Nervous System 1877

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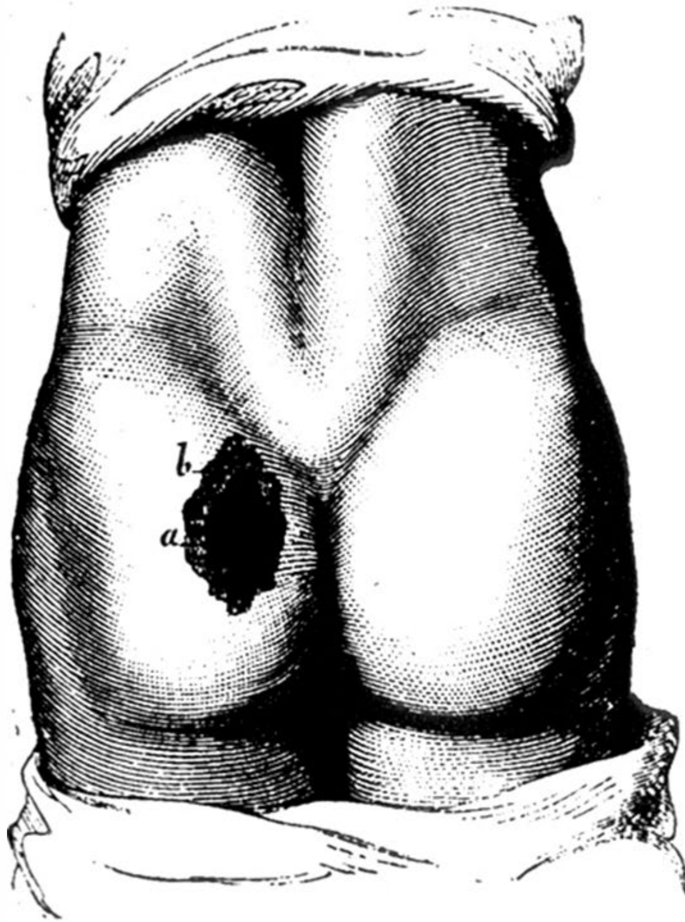
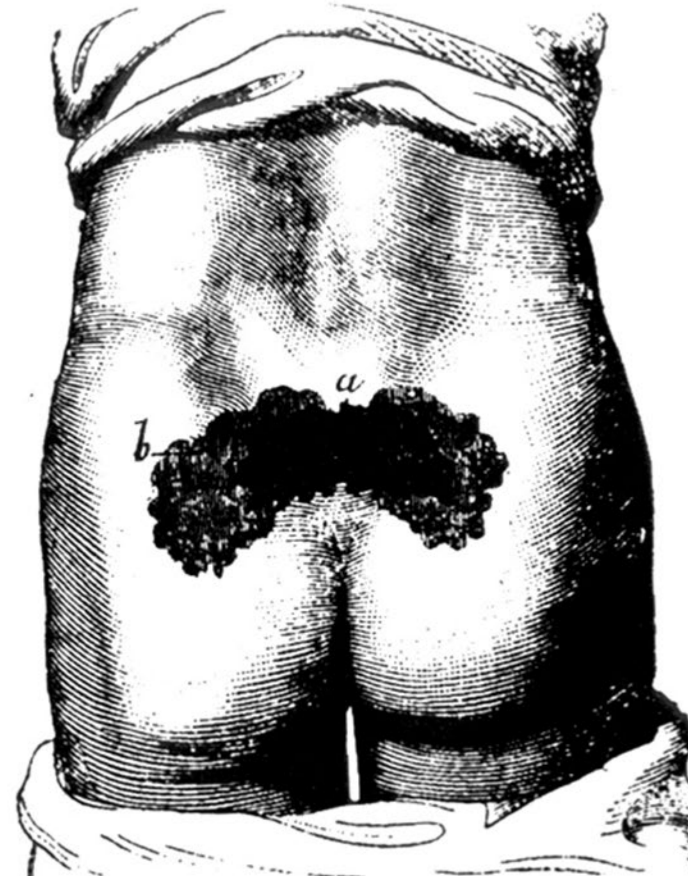
Levine JM. *J Am Geriatr Soc.* 1992;40(12):1281-1283. Levine JM. *J Am Geriatr Soc.* 2005;53(7):1248-1251.

Decubitus Ominosis





Charcot illustration courtesy of JM Levine

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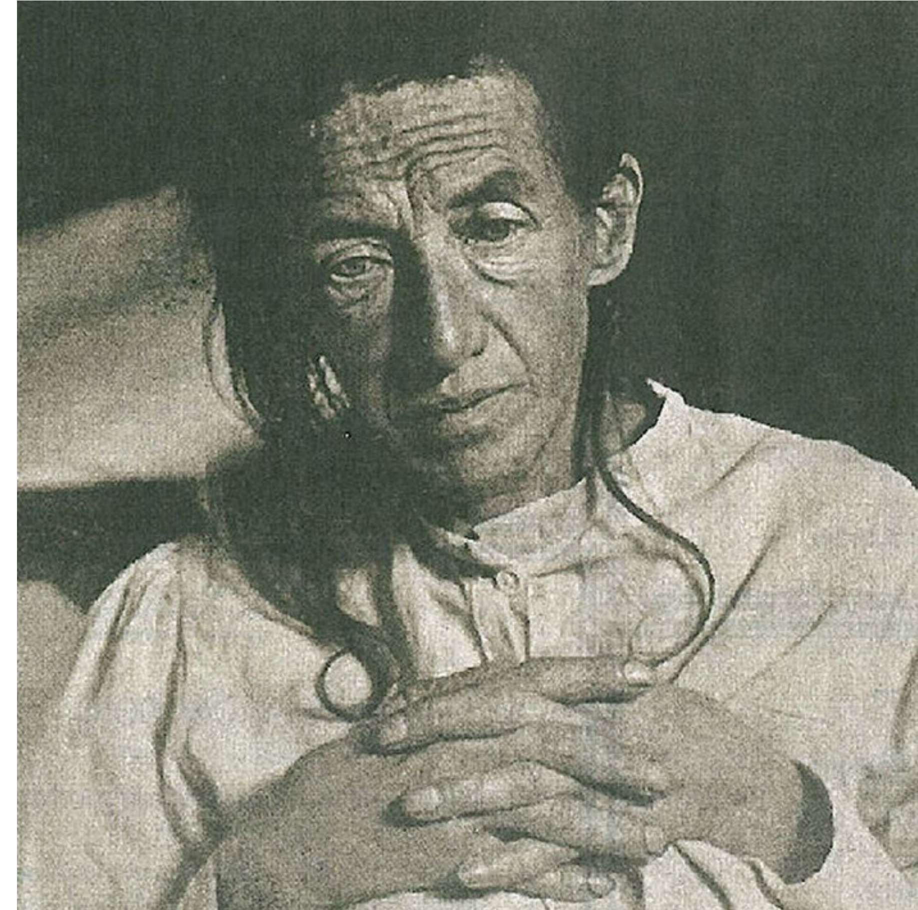
http://www.jeffreymlevinemd.com/charcot-on-pressure-ulcers

Alois Alzheimer
Frau August D

Died April 8, 1906
Septicaemia due to decubitis

Shenk D,
The Forgetting
2001, p. 22



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Shenk D. *The Forgetting*. New York, NY: Anchor Books; 2001.

La Puma 1991 The Ethics of Pressure Ulcers

The skin is the largest organ of the body. If the heart, lungs, and kidneys are showing signs of failing, isn't it logical that the skin would also show signs of failing? Why is a pressure ulcer considered a sign of inadequate health care, when symptoms of heart disease or lung disease or kidney disease are not? In the terminally ill patient, a pressure ulcer may only be a sign of physical decline and mortality. Yet in many instances, vigorous, costly, and likely ineffective treatments are instituted for advanced pressure ulcers at the same time that "Do Not Resuscitate" orders are written for a patient with a failing heart and lungs. Is this warranted? Would it be better to consider the goals of the individual patient and strive to keep the patient comfortable rather than attempt to cure a pressure ulcer?

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La Puma J. *Decubitus.* 1991;4(2):43-45.

Witkowski & Parish 2000 Skin Failure

"If the heart, lungs, and kidneys are failing,

is it not logical that the body's cover

would also show signs of failure?"

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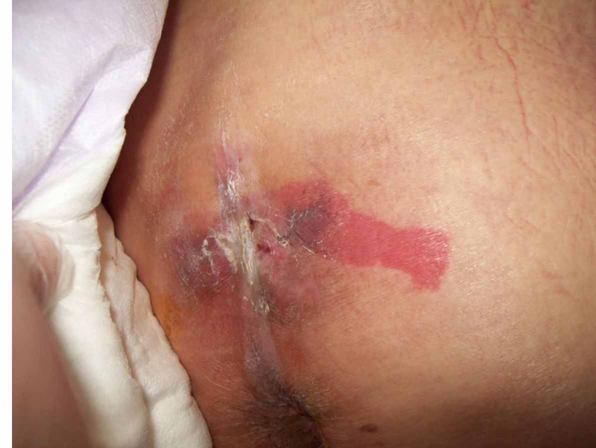
Witkowsky JA, et al. *Int. J. Dermatol*. 2000;39(12):894-896.

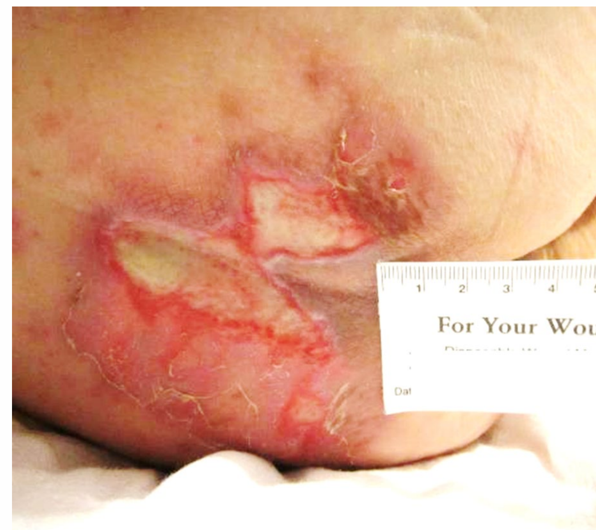
Karen Lou Kennedy Evans

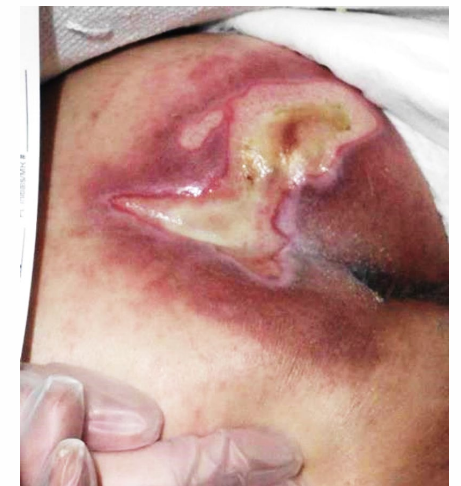
The Kennedy Terminal Ulcer (KTU)

3:30 Syndrome

1989







Kennedy KL. *Decubitus.* 1989;2(2):44-45. Kennedy Terminal Ulcer. http://www.kennedyterminalulcer.com. Accessed March 27, 2020.

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Kennedy Terminal Ulcers

Kennedy Terminal Ulcers have two presentations:

1. Kennedy Terminal Ulcer, which has bilateral presentation, usually on the sacrum coccygeal region, shaped like a pear, butterfly or horseshoe and precedes the patient's death by approximately two weeks to months.

2. 3:30 Syndrome, which is a unilateral presentation, comes on suddenly, looks like a deep tissue injury, progresses rapidly, and precedes the patient's death by usually 24-48 hours.

Kennedy KL. *Decubitus*. 1989;2(2):44-45. Kennedy Terminal Ulcer. http://www.kennedyterminalulcer.com. Accessed March 27, 2020.

Langemo & Brown 2006

SKIN FAILURE

Acute Skin Failure

Chronic Skin Failure

End Stage Skin Failure

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Langemo DK, et al. *Adv Skin Wound Care.* 2006;19(4):206-2011.

2008 Creation of an International Expert Panel

Dr. Thomas Stewart, co-founder of the NPUAP, convened an international expert panel April 4-6, 2008, in Chicago, IL, to explore issues surrounding skin changes and wounds that people experience when they are dying.

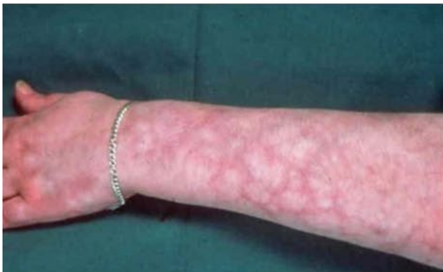
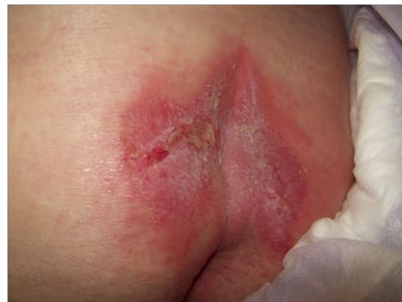
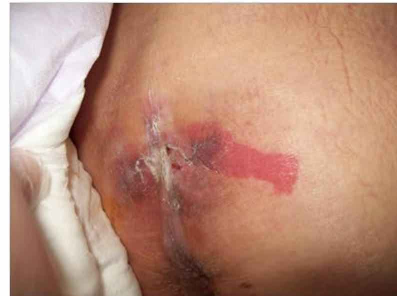
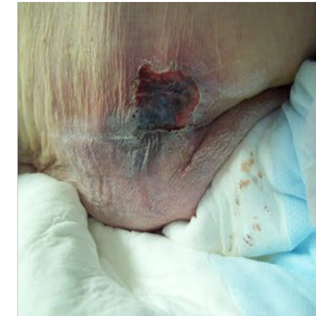
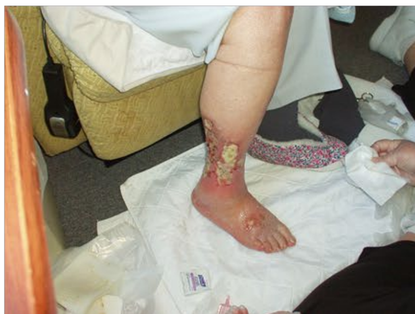
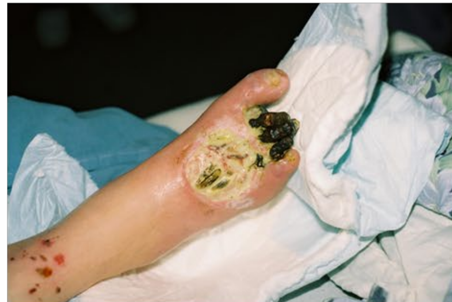
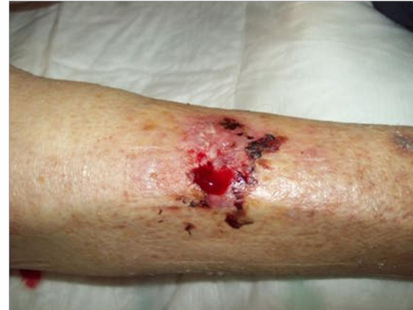
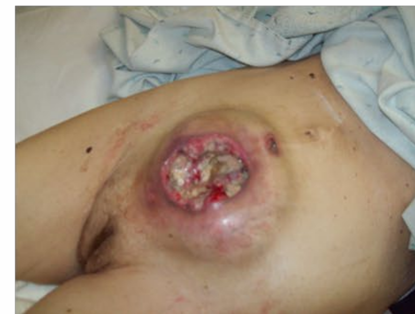
The panel included physicians, nurses, legal experts, researchers, caregivers, and a medical writer. All panel members had extensive experience with the subject matter.

The panel drafted 10 statements and decided to use a modified Delphi Process to reach consensus and then develop a consensus document on the subject.

NPUAP = National Pressure Ulcer Advisory Panel.

A Range of Skin Changes & Wounds in Dying Patients:

From Mottling to Fungating Wounds (Not Just Pressure Ulcers)

Final SCALE Consensus Document

2009

SCALE documents downloadable at www.dianelkrasner.com

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SCALE Statement 1

Physiological changes that occur as a result of the dying process (days to weeks) may affect the skin and soft tissues and may manifest as observable (objective) changes in skin color, turgor, or integrity, or as subjective symptoms such as localized pain. These changes can be unavoidable and may occur with the application of appropriate interventions that meet or exceed the standard of care.

Sibbald RG, et al. *Adv Skin Wound Care.* 2010;23(5):225-236.

Trombley-Brennan

Terminal Tissue Injury 2012

TB-TTI

Skin alterations related to organ failure at the end of life. Not pressure injuries. Unavoidable.

Trombley K, et al. *Am J Hosp Palliat Care.* 2012;29(7):541-545.

Trombley-Brennan Terminal Tissue Injury

A purple maroon discoloration that may appear suddenly on the body of a patient at the end of life. The patient will exhibit these skin changes on bony and non-bony prominences. These injuries will **never** evolve into full-thickness wounds with non-viable tissue and an increase in surface area be the only change noted. No drainage will be noted, and linear and mirror images may appear on lower extremities. Patients will not appreciate any discomfort with these areas of skin changes.

Trombley K, et al. ***Am J Hosp Palliat Care*****. 2012;29(7):541-545.**

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Ayello et al. Reexamining the Literature on Terminal Ulcers, SCALE, Skin Failure, and Unavoidable Pressure Injuries, Advances, March 2019.

Decubitus Ominosis

Kennedy Terminal Ulcer

Skin Failure (Acute, Chronic, End Stage)

SCALE Wounds

Trombley-Brennan Terminal Tissue Injury

Ayello E, et al. *Adv Skin Wound Care*. 2019;32(3):109-121.

Jeffrey M. Levine 2016-2020

Skin Failure: An Emerging Concept

Levine JM. *J Am Med Dir Assoc.* 2016;17(7):666-669. Levine JM. *Adv Skin Wound Care.* 2017;30(5):200-202.

Acute Skin Failure

The state in which tissue tolerance is so compromised that cells can no longer survive in zones of physiologic impairment such as hypoxia, local mechanical stresses, impaired delivery of nutrients, and buildup of toxic metabolic byproducts.

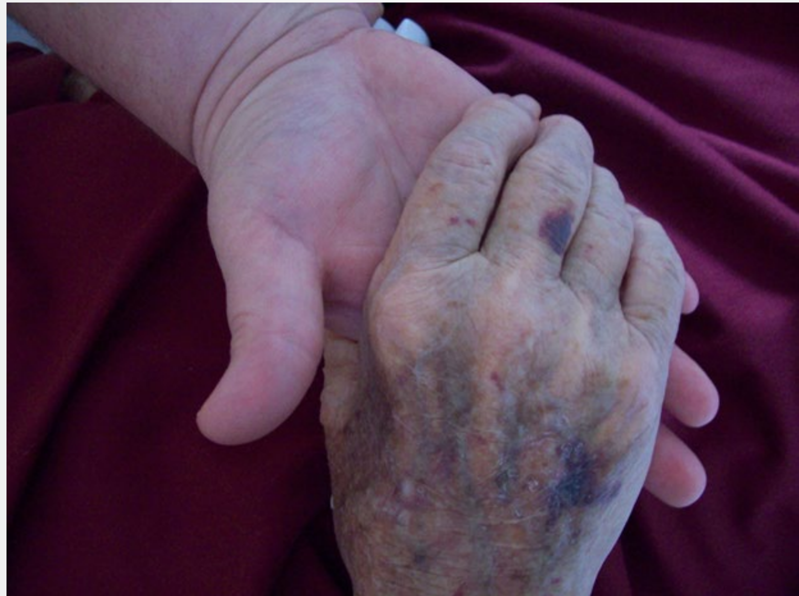
Levine JM. *Adv Skin Wound Care*. 2020;33(1):12-19.

Chronic Skin Failure

Disruption in skin integrity that fails to heal in a normal sequential manner to regain structure and function.

Levine JM. *Adv Skin Wound Care*. 2020;33(1):12-19.

The Latest on End-of-Life Wounds



NPIAP Conference February 27-28, 2020

The 5 Terms were considered and concept analysis was undertaken.

NPIAP Conference February 27-28, 2020

No consensus was reached.

To be continued . . .

So, Where Are We Today?

So, Where Are We Today?

For every complex problem,

There is a simple solution,

And it is wrong.

- HL Menken

A final thought:

Goals of care, plans of care, interventions, outcomes & documentation **MUST** address end-of-life wounds **(or whatever you choose to call them)**

PACS Attendees:

Please write your questions down on the question cards and we will collect them for the panel session

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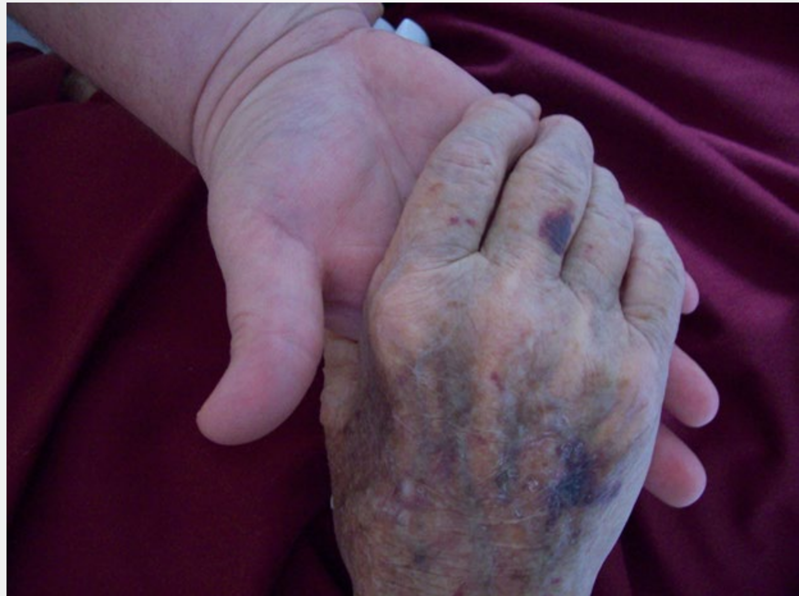


Palliative Wound Care

Martha R. Kelso

True or False:

You can only have a palliative wound if the patient is on hospice services.

A. True

B. False

True or False:

If a hospice patient has a wound it should be listed as palliative.

A. True

B. False

True or False:

If a patient is on hospice and a doctor, nurse practitioner, or physician assistant treats the patient for their wound, it must be billed to hospice.

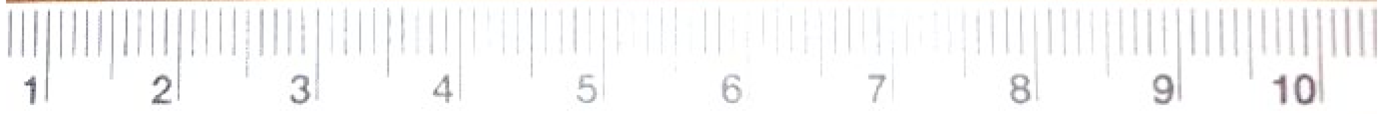
A. True

B. False

Palliative Wound Definition-

- Wound no longer responds to curative treatment
- Patient's condition no longer responds to curative treatment
- Goal is to relieve suffering, improve quality of life, promote dignity and/or prevent wound deterioration when possible
- The above statements are true regardless of the patient's hospice status
- Palliative care does not mean do not treat or prevent exacerbation of other problems or attempts to prevent new wound or skin issues from developing

Beers EH, et al. *Surg Clin North Am*. 2019;99(5):899-919 . Emmons KR, et al. *J Wound Continence Ostomy Nurse*. 2010;37(6):639-644.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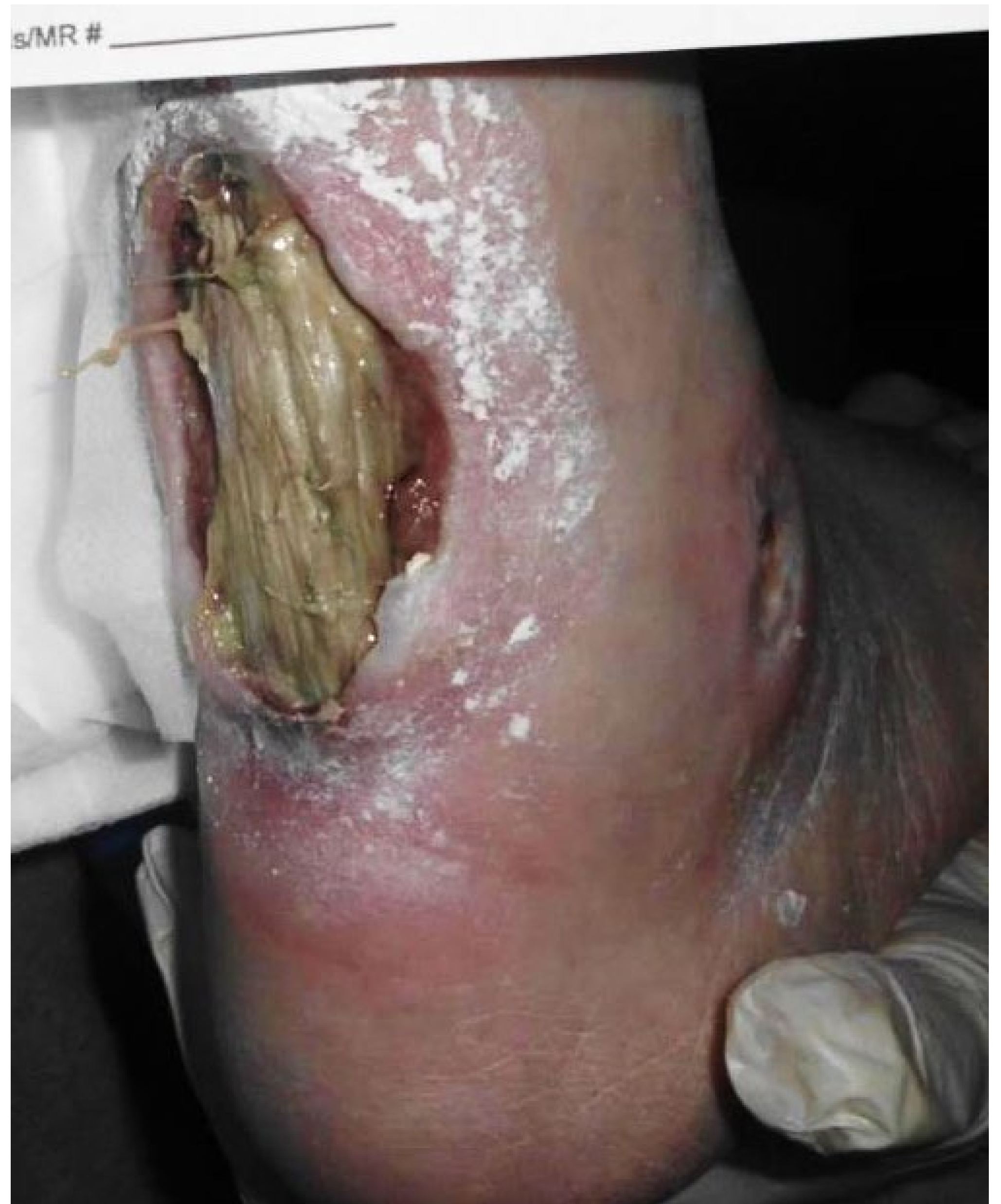
s/MR #

Palliative Wound Goals-

- Consider psychosocial impact of wounds on patient/family
- Focus on patient needs and desires
- Allow patient/family to set goals
  - Encourage them to focus on management of wound related symptoms
  - Address pain control
  - Manage exudate and microclimate
  - Contain odor
  - Control bleeding/friability
  - Relieve pruritus

Beers EH, et al. *Surg Clin North Am*. 2019;99(5):899-919. Emmons KR, et al. *J Wound Continence Ostomy Nurse*. 2010;37(6):639-644.

Patients are perceived to be experts in their care, and they should be empowered to take part in selecting the most appropriate treatment, monitoring response to treatment, and communicating concerns to their healthcare providers.

Woo K, et al. *Adv Skin Wound Care*. 2015;28(3):130-140.

Assessment for Pressure Injury Development

- Validated tools for palliative and end-of-life care for pressure injuries
  - Risk factors include advanced age
  - Physical inactivity
  - Immobility
  - Poor food and fluid intake
  - Incontinence
  - Compromised immunity
  - Poor oxygenation
  - Diminished level of consciousness
  - Lean body types
- *Palliative Performance Scale*
- *F.R.A.I.L. Healing Probability Assessment Tool*

FRAIL = For Recognition of the Adult Immobilized Life.
Woo K, et al. *Adv Skin Wound Care*. 2015;28(3):130-140.

Pain Assessment:

- Subjective
- Patient’s self report is most reliable assessment
- Psychological indicators
- Behavioral manifestations
- Functional assessments
- Diagnostic tests
- Wong-Baker Scale
- FACES
- Non-verbal cues

Pain Management:

- Silicone versus gauze
  - Granulation tissue and capillary loops do not grow into dressing, cause pain or bleeding upon removal
  - Silicone can be occlusive assisting with moist wound management
- Reach for longer wear dressings
- NPWTd (negative pressure wound therapy dressings)
- Turn at least every 4 hours with pressure redistribution combined with shearing elimination but customize to promote comfort and maintain dignity
- Consider topical cleansers that reduce pain, eliminate bacteria, or have a calming effect (ie, hypochlorous acid)

Pain Management:

- Reduce fears about opioid addiction
  - Education
  - Support
  - Open discussions
- Speak to pharmacist about compoundable drugs that meet objectives for wound and patient. Ask about half life of medications so reapplication can occur before drug wears off.
- Consider non-pharmacological management and use in conjunction

World Health Organization's Analgesic Ladder

III°
strong opioids
+/- non opioid analgesics
+/- adjuvant analgesics

Moderate to severe pain intensity

II°
weak opioids
+/- non opioid analgesics
+/- adjuvant analgesics

Mild to moderate pain intensity

I°
non opioid analgesics
+/- adjuvant analgesics

Mild pain intensity

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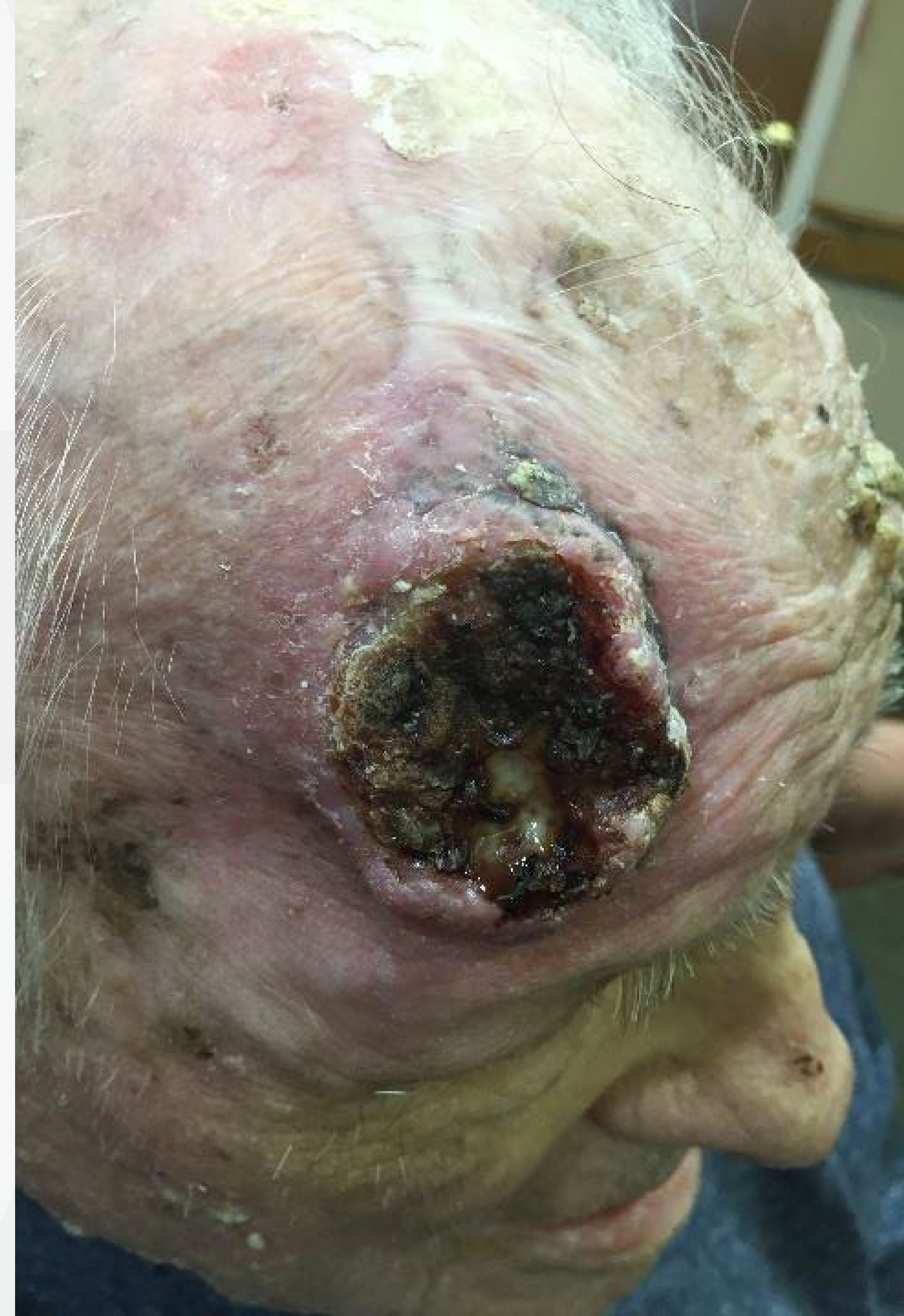
Odor:

- Topical application of metronidazole
  - Gel
  - Cream
  - Crushed tablets
  - Oral
  - Powder
- Activated charcoal - evidence is questionable
- Aromatherapy
- Vinegar
- Occlusive dressings
- Remove necrotic tissue when possible and appropriate



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Tips:

- Manage drainage
- Protect healthy skin
  - Hydrocolloids
  - Skin barrier films
    - Some last up to 7 days and allow sweat through but does not allow moisture to penetrate the barrier
  - Manage microclimate
  - Eliminate soap-alters pH
  - Use products designed to keep skin pH balanced
  - Keep dry gangrene dry

Beyond Pressure Redistribution

- Skin moisture and temperature (skin microclimate) can influence tissue tolerance to pressure, friction, and shear increasing the risk of tissue damage
- The ability of a support surface to dissipate heat and moisture contributes to patient comfort

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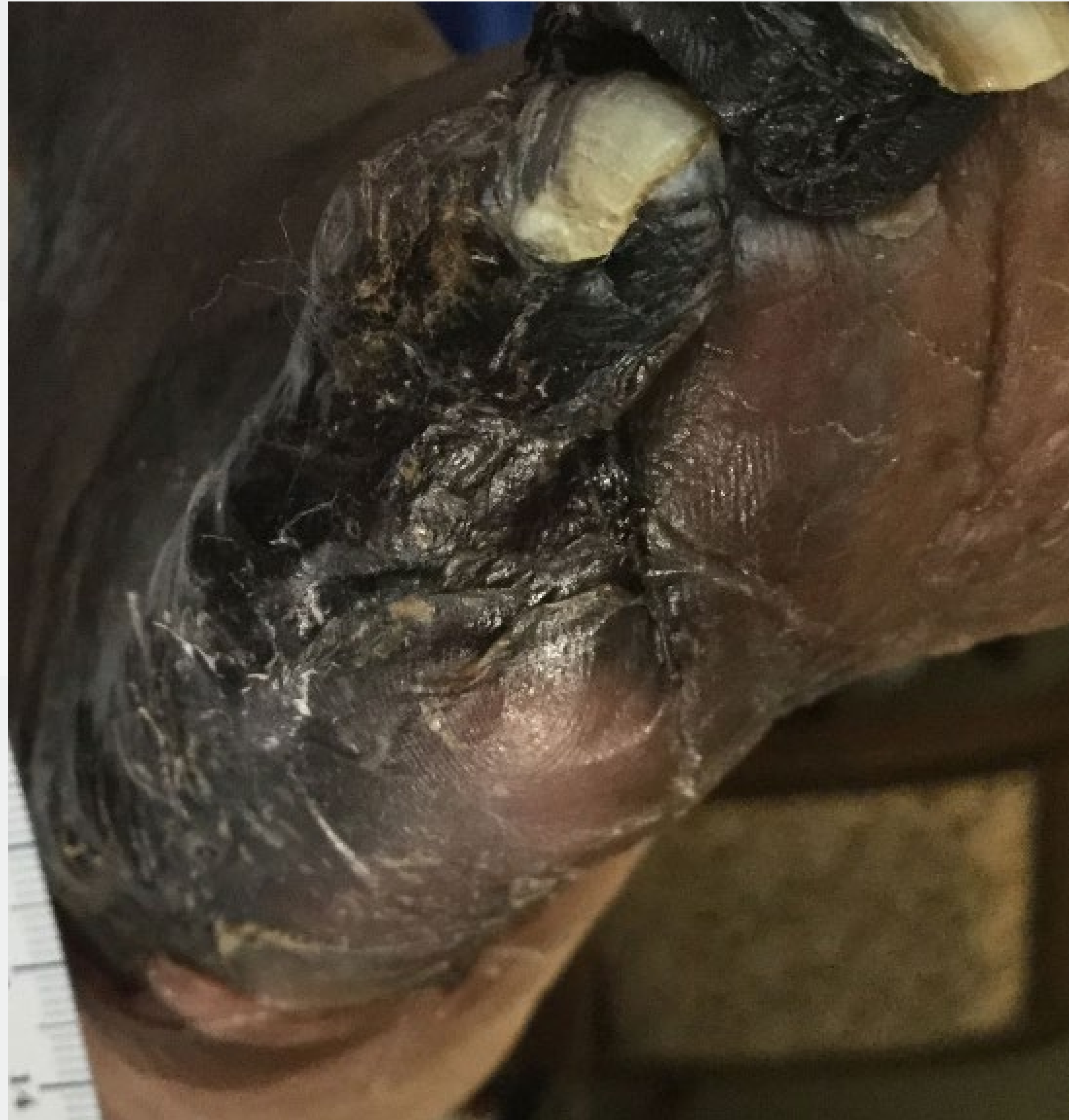

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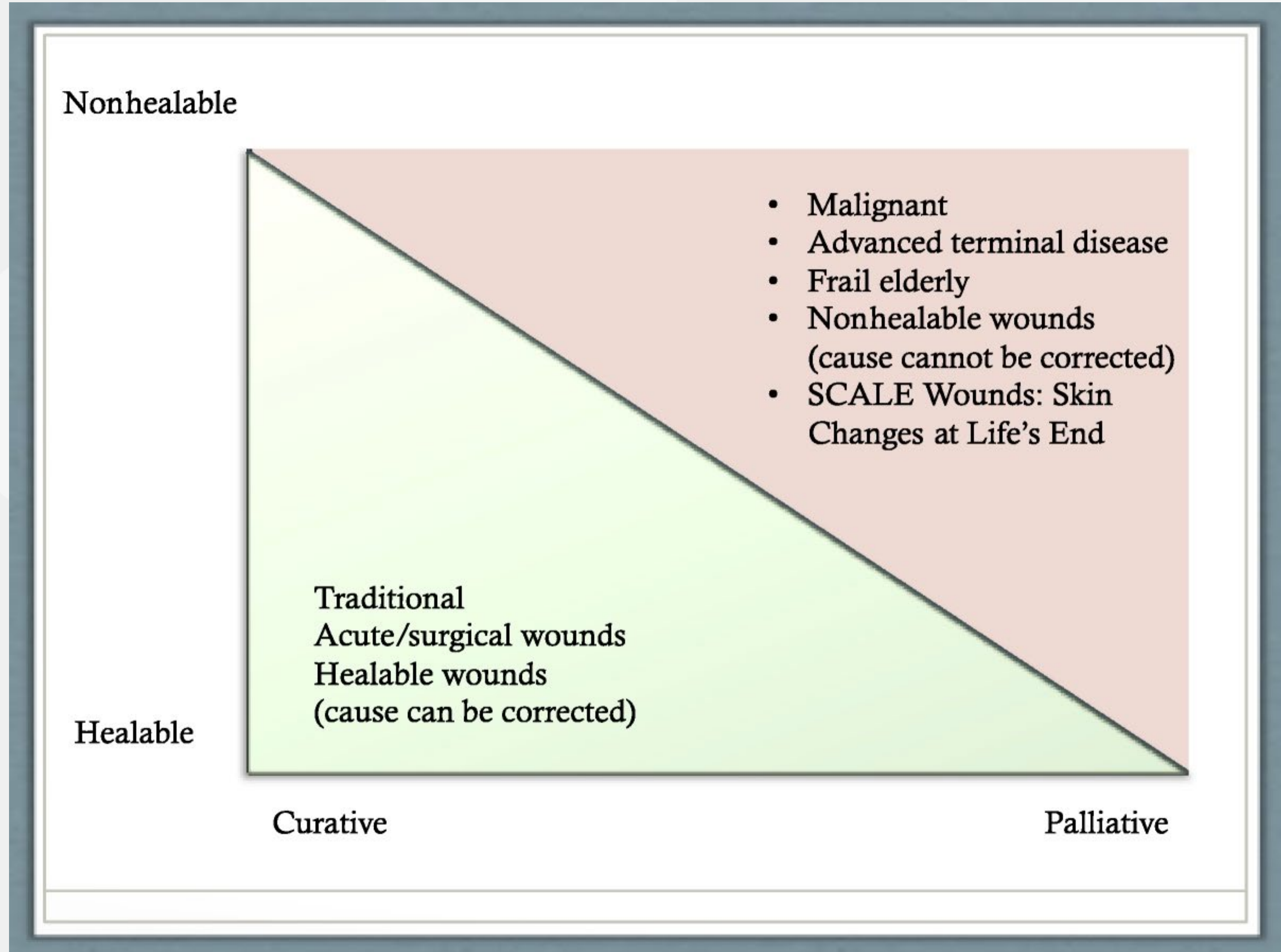

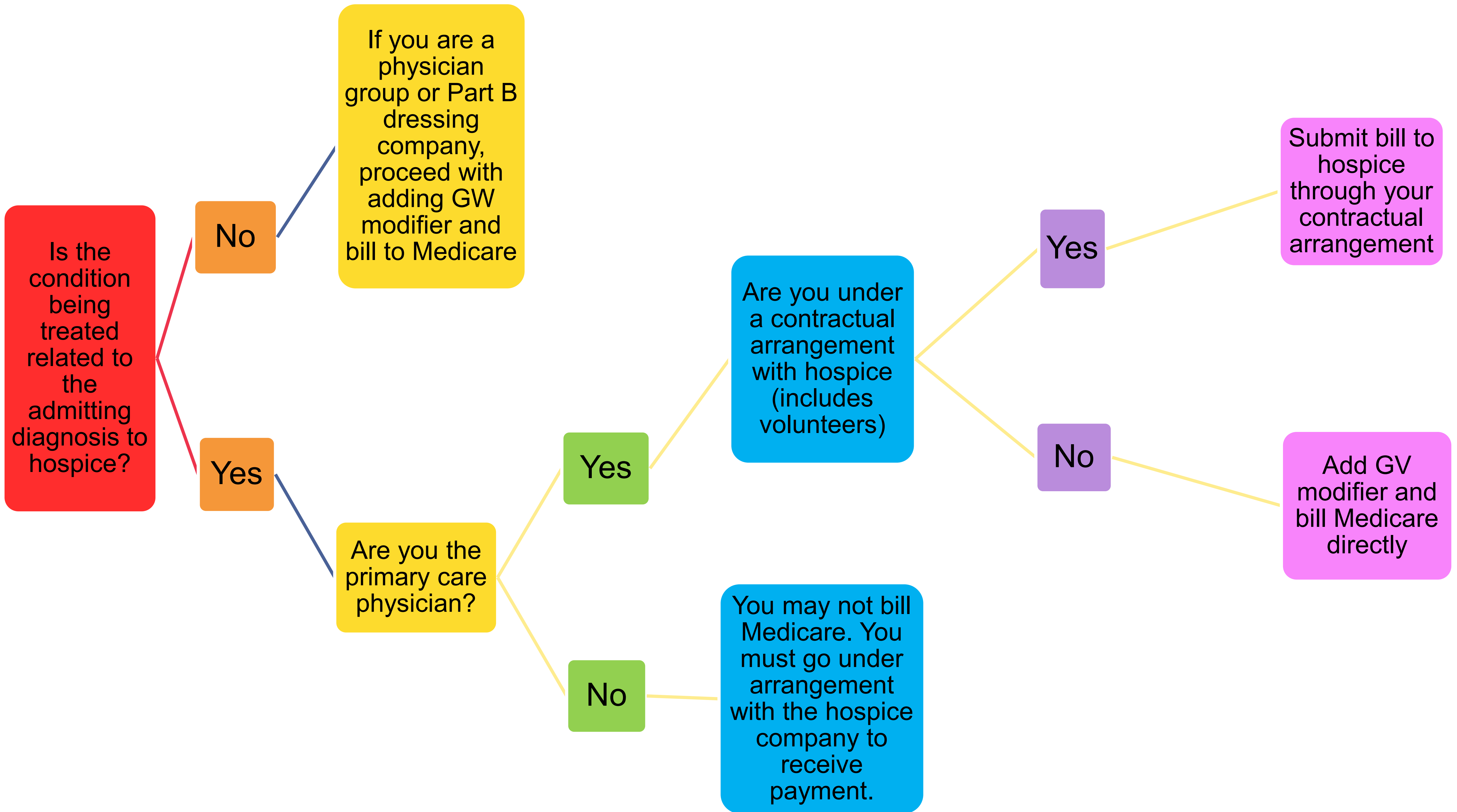

Is the condition being treated related to the admitting diagnosis to hospice?
No
If you are a physician group or Part B dressing company, proceed with adding GW modifier and bill to Medicare
Yes
Are you the primary care physician?
Yes
Are you under a contractual arrangement with hospice (includes volunteers)
Yes
Submit bill to hospice through your contractual arrangement
No
Add GV modifier and bill Medicare directly
No
You may not bill Medicare. You must go under arrangement with the hospice company to receive payment.

Kelso References

Beers, E. H. (2019). Palliative wound care: Less is more. *Surg Clin North Am*, *99*(5), 899–919. https://doi.org/10.1016/j.suc.2019.06.008

Emmons, K. R., & Lachman, V. D. (2010). Palliative wound care: A concept analysis. *J Wound Ostomy Continence Nursing*, *37*(6), 645–636. https://doi.org/10.1097/WON.0b013e181f90a4a

Langemo, D., Anderson, J., Hanson, D., Thompson, P., & Hunter, S. (2007). Understanding palliative wound care. *Wound & Skin Care*, *January*, 65–66.

Woo, K., Krasner, D., Kennedy, B., Wardle, D., & Moir, O. (2015). Palliative wound care management strategies for palliative patients and their circles of care. *Advances in Skin & Wound Care*, *28*(3), 130–140. https://doi.org/10.1097/01/ASW.0000461116.13218.43

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THE END

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